



Commonwealth of Kentucky Employee Group Life Insurance Program Enrollment/Change/Termination Form

Standard Insurance Company
Group Policy Number: 641682-A

Please complete and print all information. Please use black or blue ink only.

SSN _____ Location Name _____
Specify name of Agency, School Board or Health Dept.

Name _____ Location Number _____ Birthdate _____
Last First MI (MM-DD-YYYY)

Address _____ Annual Salary _____ Gender _____ M _____ F
Street

_____ Hire Date _____ Work Number _____
City County State Zip

A. Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Eligible employees are insured at no cost to the employee for the Basic Life and AD&D Insurance
 ALL ELIGIBLE EMPLOYEES \$20,000 Cost: \$1.96 (employer paid)

B. Optional Life and Accidental Death and Dismemberment (AD&D) Insurance (Select One Plan)

I wish to ___enroll* in, ___change* to, ___terminate the optional insurance plan checked:

- Plan 1 _____ \$ 5,000
- Plan 2 _____ \$10,000
- Plan 3 _____ One times annual salary**
- Plan 4 _____ Two times annual salary**

	<u>AGE BAND</u>	<u>RATE PER \$1,000</u>
MONTHLY CONTRIBUTION =	Under 40	0.21
	40 - 59	0.50
	60 and over	0.80

*Evidence of Insurability may be required depending on the circumstances and/or for Insurance over \$150,000.

**Under plans 3 and 4, Insurance amounts will be rounded to the nearest multiple of \$1,000. Amounts of insurance do not automatically increase with a salary change.

C. Dependents Life Insurance (Select One Plan)

Please ___enroll* my dependents in, ___change* my present plan to, or ___terminate the plan checked below:

	<u>Plan A</u>	<u>Plan B</u>	<u>Plan C</u>	<u>Plan D</u>	<u>Plan E</u>
Spouse	\$10,000	\$5,000	\$5,000	\$10,000	--
Dependent Children to 6 mos.	\$ 2,500	\$1,500	--	--	\$2,500
6 months to 18 years**	\$ 5,000	\$3,000	--	--	\$5,000
MONTHLY CONTRIBUTION =	\$10.00	\$5.35	\$2.25	\$7.90	\$3.25

*Evidence of Insurability may be required depending on the circumstances.

**18 and older if attending an educational institution and relying on the employee for financial support.

D. Waiver of Optional Life and Dependents Coverage

I certify that I have been given the opportunity to enroll myself and my eligible dependents in the above coverage. I have declined the Optional and/or Dependents Life coverage and understand that it will be necessary for me and my dependents to furnish evidence of insurability if I desire any of the above coverage in the future (other than during an open enrollment period or other exception detailed in the certificate booklet).

E. Employee Signature and Date (Required)

Employee Signature _____ Date _____

To Be Completed by the Insurance Coordinator

IC Signature _____ Date _____

Effective Date for: ___Enrollment ___Change ___Termination

Basic Insurance _____

Optional Insurance _____

Dependents Group Term Life _____

In case of change or termination:

Employment Termination Date _____

OR

Date of Qualifying Event _____

Description of Qualifying Event _____

Send PERSONNEL CABINET COPY TO:

Personnel Cabinet
Group Life Insurance Administration
200 Fair Oaks Lane, Room 503
Frankfort, KY 40601

PERSONNEL COPY